DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/11/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445373	A. BUILDING _____ B. WING _____	06/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHSIDE HEALTH CARE NURSING AND REHABILITATION C	202 EAST MTCS ROAD MURFREESBORO, TN 37130

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey and complaint investigation #33762 and #33900, were completed at Northside Health Care Nursing and Rehabilitation Center on June 23 - 25, 2014. No deficiences were cited related to complaint investigation #33762 and #33900, under 42 CFR Part 483, Requirements for Long Term Care Facilities.	F 000		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review, facility hospice agreement review, and interview, the facility failed	F 279	F-279 483.20(d), 483.20(k)(1) SS=D DEVELOP COMPREHENSIVE CARE PLANS Requirement: The facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under #483.25; and any services that would otherwise be required under #483.25 but are not provided due to the resident's exercise of rights under #483.10, including the right to refuse treatment under #483.10(b)(4).	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator 7/31/14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 279	Continued From page 1 to ensure a Hospice Plan of Care was in place for one resident (#23) of seven Hospice residents reviewed of thirty-one residents reviewed. The findings included: Resident #23 was admitted to the facility on January 3, 2014, with diagnoses including Depressive Disorder, Generalized Anxiety, Cerebral Vascular Accident, Congestive Heart Failure, Aphasia, and Hypertension. Medical record review of a Physician's order dated January 8, 2014, revealed an order for a Hospice consult. Continued review revealed an order dated January 12, 2014, to admit to Hospice services. Review of the Facility and Hospice Agreement dated October 28, 2013, revealed, "...HOSPICE shall develop and maintain a written Hospice Plan of Care. The Hospice Plan of Care will identify which provider is responsible for performing the respective functions that have been agreed upon and included in the Hospice Plan of Care..." Interview with the Regional Nurse Consultant at the nurse's station on June 25, 2014, at 10:00 a.m., confirmed the facility had failed to ensure a hospice plan of care was developed.	F 279	**Corrective Action:** 1. On 6/25/14, the Hospice Agency faxed the facility a copy of the Hospice Plan of Care and the DON placed in the resident's Hospice Chart and electronically scanned into their Electronic Medical Record (EMR) to ensure the nursing staff have the appropriate access. 2. On 6/25/14, the DON, ADON, and Regional Nurse Consultant conducted an audit to ensure all hospice resident's had a Hospice Plan of Care in their Hospice Chart and in the EMR to ensure access by nursing staff. 3. On 6/25/14 the DON and Staffing Coordinator conducted an in-service with the MDS Coordinator and the nursing staff stating that all Hospice residents must have their Hospice Plan of Care in the EMR for access by nursing staff.	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced	F 281	4. The DON and/or other designee will review all new Hospice residents upon admission for appropriate documentation x 60 days and will report their findings to the quarterly QA&A Committee.	07/31/14

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F 281	Continued From page 2 by: Based on medical record review, facility provided instructions, observation, and interview, the facility failed to administer an inhaler per facility policy and instructions for one (#96) of five residents reviewed for medication administration. The findings included: Resident #96 was admitted to the facility on May 19, 2014, with diagnoses including Diabetes Mellitus, Anemia, Hypertension, and Pneumonia. Medical record review of the Minimum Data Set dated May 26, 2014, revealed the resident had a Brief Interview for Mental Status score of 9 which indicates the resident has some moderate cognitive impairment. Continued medical record review of the Physician's Recapitulation Orders for June 2014 revealed, "...Flovent (type of corticosteroid inhaler)...two puffs two times daily..." Observation of Licensed Practical Nurse (LPN) #1 in the resident's room on June 24, 2014, at 7:37 a.m., revealed LPN #1 administered the Flovent inhaler to the resident and failed to give instruction to the resident for inhaler use prior to administration. Continued observation revealed the resident took two consecutive puffs, without waiting between puffs and handed the inhaler back to the LPN. Further observation revealed the LPN failed to have the resident rinse the mouth after use. Review of facility policy, Inhaler Administration, revealed, "...8. Explain procedure to resident...14. Ask resident to breathe out...16. Press down on inhaler once to release medication as resident	F 281	**F-281** **SS=D** **483.20(k)(3)(i)** **SERVICES PROVIDED MEET PROFESSIONAL STANDARDS** **Requirement:** The services provided or arranged by the facility must meet professional standards of quality. **Corrective Action:** 1. (a) On 6/25/14, Nurse # 1 was immediately inserviced by the DON on medication administration. (b) The DON placed medication administration guidelines for inhalers in three ring binders on all med carts. 2. The DON conducted visual audits to ensure that other residents received medications as ordered by the Physician. 3. The Staffing Coordinator conducted inservice training on 6/25/14 for all licensed nursing staff regarding the appropriate procedures for administering inhalers and that medication administration guidelines for inhalers were placed in binders on all med carts for review.	

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F 281	Continued From page 3 starts to breathe in slowly through the mouth over 3- 5 seconds...17. Resident should hold breath...18. If another puff of the same or different medication is required, wait 1-2 minutes...19. For steroid inhalers, provide resident with cup of water and instruct him/her to rinse the mouth and spit water back into cup..." Interview with LPN #1, at the nurse's desk, on June 24, 2014, at 8:28 a.m., confirmed the LPN did not follow facility policy for inhaler administration. Interview with the Director of Nursing (DON) in the DON's office on June 25, 2014, at 8:52 a.m., confirmed the facility had failed to follow the policy for oral inhalation administration.	F 281	4. The DON, ADON, Staffing Coordinator, and/or other designee will conduct weekly medication pass audits x 30 days and randomly thereafter to ensure licensed nursing staff adhere to the medication administration guidelines for inhalers and will report their findings to the quarterly QA&A Committee.	07/31/14
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of dialysis communication forms, facility policy review, and interview, the facility failed to provide the necessary care and services was provided prior to and after dialysis for one (#46) of one resident receiving dialysis.	F 309	**F-309** **SS=D** **483.25** **PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING** **Requirement:** Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	

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F 309	Continued From page 4 The findings included: Resident #46 was admitted to the facility on November 8, 2012, with diagnoses including Congestive Heart Failure, End Stage Renal Disease, and Atrial Fibrillation. Medical record review of the June 2014 Physician Recapitulation Orders revealed "...dialysis as scheduled...three times weekly..." Review of facility communication forms and nursing documentation revealed no documentation of the condition of the patient before dialysis and upon return for the following dates: June 12, May 1, 3, 6, 22, and 27, April 3, 5, 8, 12, and 26, 2014. Review of facility policy, Dialysis Patient Services, revealed "...3. Communication is essential to the care of a dialysis patient...5. Nursing documentation required: Condition of patient before dialysis and upon return..." Interview with the Director of Nursing (DON) on June 25, 2014, at 8:52 a.m., in the DON's office, confirmed the facility had failed to provide the necessary care and services prior to and after dialysis.	F 309	**Corrective Action:** 1. (a) On 6/25/14, the facility obtained documentation from the Dialysis Clinic for the missing dates for resident #46 and (b) the DON placed missing documentation in Dialysis binder and scanned into the EMR. 2. Resident #46 is currently the only resident at the facility receiving dialysis. 3. On 6/25/14, the Staffing Coordinator inserviced all licensed nursing staff on proper pre and post dialysis procedures and documentation and on obtaining the appropriate documentation upon resident's return from dialysis. Nursing staff were also inserviced on if residents return from dialysis without the documentation, the nursing staff are to contact the Dialysis Clinic and obtain the information for the EMR. A Dialysis binder was placed at the nurses' station to maintain all dialysis documentation and communication.	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 312		

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F 309	Continued From page 4 The findings included: Resident #46 was admitted to the facility on November 8, 2012, with diagnoses including Congestive Heart Failure, End Stage Renal Disease, and Atrial Fibrillation. Medical record review of the June 2014 Physician Recapitulation Orders revealed "...dialysis as scheduled...three times weekly..." Review of facility communication forms and nursing documentation revealed no documentation of the condition of the patient before dialysis and upon return for the following dates: June 12, May 1, 3, 6, 22, and 27, April 3, 5, 8, 12, and 26, 2014. Review of facility policy, Dialysis Patient Services, revealed "...3. Communication is essential to the care of a dialysis patient...5. Nursing documentation required: Condition of patient before dialysis and upon return..." Interview with the Director of Nursing (DON) on June 25, 2014, at 8:52 a.m., in the DON's office, confirmed the facility had failed to provide the necessary care and services prior to and after dialysis.	F 309	4. The DON, Medical Records, and/or other designee will conduct weekly audits x 60 days of the Dialysis Communication binder and randomly thereafter to ensure appropriate documentation and communication is maintained for all dialysis residents and will report to the quarterly QA&A Committee.	07/31/14
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 312	**F 312 SS=D 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS** **Requirement:** A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	

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F 312	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on review of Certified Nurse Assistant (CNA) Assignment Sheet, observation, and interview, the facility failed to provide grooming for one (#100) of thirty-one residents reviewed. The findings included: Resident #100 was admitted to the facility on June 13, 2014, with diagnoses including Diabetes, Dementia, Hypertension, and Stroke. Review of the CNA Assignment Sheet for the Day Shift and the Evening Shift revealed "...Men shaved daily or as desired, facial hair removed from female patients..." Observation on June 24, 2014, at 2:30 p.m., in resident #100's room revealed the resident had facial hair on both sides of the face and on the chin; the hair was approximately ¼ inch long. Interview with resident #100 on June 24, 2014, at 2:30 p.m., revealed "I don't like hair like that." Observation on June 25, 2014, at 9:00 a.m. and at 3:00 p.m., in the resident's room revealed the resident continued to have the facial hair on the sides of the face and the chin. Observation with the Director of Nursing (DON) on June 26, 2014, at 9:04 a.m., in resident #100's room revealed the resident continued to have the facial hair on the sides of the face and on the chin. Interview with the DON, at the time of the observation, confirmed the resident had been	F 312	**Corrective Action:** 1. On 6/25/14, CNA shaved the sides of the face and chin of the female resident #96. 2. The DON, ADON, and RNC conducted random audit of female residents on 6/25/14 that revealed no other female residents with unwanted facial hair. 3. On 6/25/14, Staffing Coordinator conducted inservice training for all nursing staff on ensuring that female residents are free from unwanted facial hair. 4. The DON, ADON, Staffing Coordinator, and/or other designee will conduct weekly rounds and randomly thereafter to ensure all female residents are free of unwanted facial hair and will report findings to the QA&A Committee quarterly.	07/31/14

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F 312	Continued From page 6 bathed by the CNA's since Monday morning, removal of facial hair is part of the bathing process, and the resident had facial hair that had not been removed.	F 312		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility investigation, and interview, the facility failed to ensure the appropriate lift was used for transfer to prevent accidents for one resident (#28) of thirty one residents reviewed. The findings included: Resident #28 was admitted to the facility on February 2, 2014, with diagnosis of History of Falls, Dislocated Shoulder, Acute pain, Contusion of Hip, Depressive Disorder, and General Anxiety Disorder. Medical record review of the Minimum Data Set, dated March 6, 2014, revealed the resident was cognitively intact, required assistance for transfers and ambulation, and had a history of falls.	F 323	**F323** **SS=D** **483.25(h)** **FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES** **Requirement:** The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. **Corrective Action:** 1. On 6/25/14, the Staffing Coordinator identified and inserviced CNA #2 and charge nurse on appropriate use of a mechanical lift and that all lifts are only to be used with two persons participating in the transfer. 2. The DON conducted visual audits to ensure the appropriate use of a mechanical lift as specified by the manufacturer and that all lifts are only to be used with two persons participating in the transfer.	

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F 323	Continued From page 7 Medical record review of a facility investigation revealed the resident had "...a fall with no injury, on March 25, 2014, at 9:45 p.m., interventions initiated: Use Hoyer lift only for transfers with assist of two, no stand-up lift..." Continued review of the facility investigation revealed "...Certified Nursing Assistant (CNA) was transferring resident with sit to stand lift (Stand-up lift), resident let go and CNA lowered resident to floor..." Interview with CNA #1 on the 200 hall, on June 25, 2014, at 10:20 a.m., revealed the CNA had been in-serviced on the stand up lift and the Hoyer lift during staff orientation, and at least once per year for all nursing staff. Continued interview with the CNA revealed the CNA demonstrated the procedure for lift use for the stand-up lift and the Hoyer lift. Further interview with the CNA revealed when questioned about the possibility of a resident sliding out of the stand-up lift the CNA stated "...a resident could not slip out of the lift if the seat was properly attached...there should always be two people to assist with transfers with either (stand-up or Hoyer) lift..." Interview with CNA #2 by telephone on June 25, 2014, at 1:20 p.m., revealed the CNA remembered transferring the resident to the bed with the stand-up lift on March 25, 2014, and stated "...was transferring the resident alone when the resident slid out of the lift and was lowered to the floor by holding on to...pants..." Continued interview with the CNA revealed when questioned about the facilities policy for transferring residents with a stand-up lift, specifically, the number of staff needed for transfers, the CNA confirmed "...two people are required for lift transfers, there was a nurse near	F 323	3. On 6/25/14, the Staffing Coordinator inserviced nursing staff on appropriate use of a mechanical lift as specified by the manufacturer and that all lifts are only to be used with two persons participating in the transfer. 4. The DON, ADON, and/or other designee will conduct weekly competency audits/skills check-offs with nursing staff x 60 days and randomly thereafter to ensure that policies and manufacturers guidelines are followed to ensure compliance and will report their findings to the quarterly QA&A Committee.	07/31/14

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F 323	Continued From page 8 the resident's room, but...told me to go ahead and get the resident in bed, so I attempted the transfer by myself..." Interview with the Director of Nursing (DON) on June 25, 2014, at 1:40 p.m., in the DON's office confirmed the facility did not have a policy for lift use and followed the manufacturers' instructions. Continued interview with the DON confirmed the DON "...the instructions written on the stand-up lift stated under paragraph #3: Whenever possible two caregivers should be present during lifting and transfer." Further interview with teh DON confirmed the facility had failed to ensure the correct lift was used for transfer resulting in a non-injury fall.	F 323		